NOVA SCOTIA PROVINCIAL PHARMACARE PROGRAMS

Request for Insured Coverage of Disease Modifying Therapies for Multiple Sclerosis

PATIENT INFORMATION

PATIENT SURNAME	PATIENT GIVEN NAME	HEALTH CARD NUMBER	DATE OF BIRTH

PATIENT ADDRESS

REQUESTED AGENT

☐ Cladribine ☐ Dimethyl Fumarate ☐ Fingolimod

Glatiramer: ☐ Glatect **OR** ☐ Glatiramer Acetate

Interferon Beta: ☐ Rebif **OR** ☐ Avonex **OR** ☐ Betaseron

☐ Natalizumab ☐ Ocrelizumab ☐ Ofatumumab ☐ Siponimod ☐ Teriflunomide

INITIAL REQUEST

☐ DMT Naive

☐ Switch from another DMT, please advise: _____

RRMS

1.) ☐ Relapsing-remitting multiple sclerosis (RRMS)

2.) ☐ History of ≥ 1 disabling relapse or new MRI activity in past 2 years (1 year for Cladribine requests). Not applicable to Interferon or Glatiramer

3.) *Current EDSS:_____ (if >6.5 complete section at bottom of form) Date:_____

OR PDDS:_____ Date:_____

4.) Cladribine or Natalizumab Requests:

☐ Refractory or intolerant to at least one disease modifying therapy (e.g., interferon, glatiramer, dimethyl fumarate, teriflunomide, ocrelizumab ofatumumab).

Please provide details: _____

SPMS (SIPONIMOD, GLATIRAMER OR INTERFERON BETA ONLY)

1.) ☐ Active secondary progressive multiple sclerosis

2.) ☐ **Siponimod Requests:** Documented EDSS progression during the two years prior to initiating treatment with siponimod:

EDSS within prior 2 years:_____ Date:_____ **OR** PDDS within prior 2 years:_____ Date:_____

3.) ☐ **Glatiramer/Interferon Requests:** Clear superimposed relapses

4.) *Current EDSS:_____ (if >6.5 complete section at bottom of form) Date:_____ **OR** PDDS:_____ Date:_____

PPMS (OCRELIZUMAB ONLY)

1.) ☐ Primary progressive multiple sclerosis

2.) ☐ Diagnostic imaging features characteristic of inflammatory activity

3.) *Current EDSS:_____ (if >6.5 complete section at bottom of form) Date:_____ **OR** PDDS:_____ Date:_____

4.) Disease Duration (select 1): ☐ < 10 years (EDSS ≤ 5.0) **OR** ☐ < 15 years (EDSS > 5.0)

5.) Current Functional Systems Scale (FSS) score for pyramidal functions due to lower extremity findings: _____ Date:_____

RENEWAL REQUEST

*Current EDSS:_____ Date: _____ (if >6.5 (or ≥7 for cladribine or natalizumab) complete section below)

OR PDDS: _____ Date: _____

*INITIAL OR RENEWAL: EDSS >6.5

*If EDSS is >6.5 (or ≥7 for cladribine or natalizumab) on initial or renewal requests, please provide additional information on the clinical rationale for treatment initiation **OR** the patient's response to therapy and clinical rationale for continuation of coverage:

PRESCRIBER NAME & ADDRESS:

_____ **LICENCE #**

_____ **PRESCRIBER SIGNATURE**

_____ **DATE**

If you need assistance, please contact the Pharmacare Office at (902) 496-7001 or 1-800-305-5026

Please Return Form To: Nova Scotia Pharmacare Programs
P.O. Box 500, Halifax, NS B3J 2S1, Fax: (902) 496-4440

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NOVA SCOTIA